STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		COMPLETED
		155505	B. WING		12/19/2013
NAME OF P	ROVIDER OR SUPPLIER	t		ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W	
ROBIN R	UN HEALTH CENT	ER	INDIAN	IAPOLIS, IN 46268	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F000000					
	This visit was fo	r a Recertification and	F000000	The following is the Plan of	
	State Licensure S	Survey.		Correction for Robin Run Heal Center regarding the Stateme	I
	Survey dates: D	ecember 12, 13, 16, 17,		of Deficiencies dated 12/19/2013. This Plan of	
	18, and 19, 2013			Correction is not to be constru	ed
	10, ши 17, 2013	•		as an admission of or agreem	ent
	Facility number:	001156		with the findings and conclusion in the Statement of Deficiencies	
	Provider number			or any related sanction or fine	
	AIM number: 100453350			Rather, it is submitted as	
				confirmation of our ongoing	
	Survey team:			efforts to comply with statutory and regulatory requirements.	
	Lora Brettnacher	r, RN-TC		this document, we have outline	
	Jeanna King, RN	J		specific actions in response to	
				identified issues. We have no	I
	Census bed type	:		provided a detailed response to each allegation or finding, nor	.0
	SNF: 19			have we identified mitigating	
	SNF/NF: 59			factors. We remain committed	I
	Total: 78			the delivery of quality health constructions and will continue to	
	Census payor typ	pe:		make changes and improvement to satisfy that objective. This	ent
	Medicare: 11	-		provider respectfully requests	that
	Medicaid: 44			this 2567 Plan of Correction b	
	Other: 23			considered the Letter of Credi Allegation of Compliance and	oie
	Total: 78			requests a Post Survey Revie	w
				on or after January 18, 2014.	
	These deficienci	es reflect sate findings			
	cited in accordar	nce with 410 IAC 16.2.			
	Ouality review o	completed 12/26/2013 by			
	Brenda Marshall	-			
		····			
F000241	483.15(a)				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

001156

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPL	ETED
		155505	B. WING			12/19/	2013
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECT			(X5)
PREFIX	-	ICY MUST BE PRECEDED BY FULL	F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG SS=E	DIGNITY AND RE	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
33-E	INDIVIDUALITY	SPECIOF					
	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's						
	or her individuality	ct in full recognition of his					
	-	ration, record review, and	F000	241	Dignity & Respect of Individua	lityIt	01/18/2014
		cility failed to provide			is the practice of the provider t	0	
	-	in a dignified and			promote care in a manner and		
		y failing to knock on			an environment that maintains and enhances each resident's		
		st permission to enter,			dignity and respect in full		
	and by failing to respond or delayed responses to residents' request for				recognition of his or her		
					individuality.What corrective		
	•	deficient practice			actions will be accomplished for those residents found to have	or	
		residents reviewed for			been affected by the deficient		
		at #16, Resident #90, and			practice:Staff were re-educate	d	
	Resident #18).	ie ii 10, resident ii 50, and			on call light response standard	ds	
	resident #10).				for Resident #90, privacy standards for Residents # 90 a	and	
	Findings include	·			#16, promoting respect and	ariu	
	i mamgo merade	•			dignity for Resident #90 and		
	1 During const	ant observation on			assisting with transportation w		
	_	en 11:45 A.M. and 12:20			indicated/requested for Reside # 16. Resident #18 has	ent	
		P.M., Resident #18 was			discharged from the facility. He	ow	
		e of her bed attempting to			other residents having the		
		s. Resident #18 pushed			potential to be affected by the		
		assistance at 11:45 A.M.			same deficient practice will be		
	_	tes passed before, CNA			identified and what corrective action (s) will be taken:Staff w	ere	
	[Certified Nursi	•			re-educated on call light respo		
	responded to the	-			standards, privacy standards,		
	135ponded to the	11 <u>0</u> 111.			promotion of dignity and respe		
	 During an interv	riew on 12/12/2013 at			and responding with timely ass to expressed/identified resider		
	_	ident #18 indicated call			needs. What measures will be		
	light waits were				into place or what systemic		
		10116.			changes will be made to ensur		
					that the deficient practice does	5	

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Event ID:

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If continuation sheet

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2)		(X2) M	X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED	
		155505	B. WIN			12/19/2013		
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	E .		6370 R	OBIN RUN W			
	UN HEALTH CENT			INDIAN	APOLIS, IN 46268			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	not recur:Staff were re-educate	- d	DATE	
		servation on 12/13/2013			on call light response standard			
	•	CNA #6 was observed to			privacy standards, promotion of			
		90's room without			dignity and respect, and			
	_	#6 left the room after			responding with timely assist to	0		
		ent #90's roommate and			expressed/identified resident	,		
		ninutes later. CNA #6			needs.How corrective action(s will be monitored to ensure the			
		mediately entered			deficient practice will not recur			
		oom without waiting for			i.e., what quality assurance			
	her permission to	o enter the room.			program will be put into place:	A		
					dignity and respect Quality Assurance Performance			
	During an interv	riew on 12/13/2013 at			Improvement audit tool will be			
	10:17 A.M., Res	sident #90 indicated staff			utilized weekly times 4 weeks,			
	did not always tr	reat her with respect and			then bi-weekly times 4 weeks	and		
	dignity. She stat	ted, "when she would			then monthly until the alleged			
	come in to wash	me she would not pull			deficient practice does not rec The Quality Assurance	ur.		
	the curtain arour	nd so no one could see			Performance Improvement			
	me. Her attitude	e was like she was the			audits, as well as the Resident	:		
	one paying me a	nd not me paying to live			Council Minutes will be review			
		ed to her they claim they			in the monthly Quality Assurar	ice		
	<u>-</u>	a lotI had waited 40			Performance Improvement meeting by the Quality Assura	nce		
	_	ny wet pants changed			Performance			
	_	in them. [Assistant			Improvementcommittee.			
		ing named] started in and						
		stood there and augured						
	_	ne time. I am not stupid.						
		on they turn that light						
		I don't even have						
		say please don't turn my						
	_	got helpI am supposed						
		on so I am not lying in my						
		spect immediate but I do						
	expect it before	•						
	expect it before.	50 mmucs						
	During an interv	riew on 12/13/2013 at						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED	
		155505	B. WIN	G		12/19/2013	
NAME OF P	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
5051115					OBIN RUN W		
ROBIN R	RUN HEALTH CENT	ER		INDIAN	APOLIS, IN 46268		
(X4) ID				ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA [*] DEFICIENCY)		
TAG		,		TAG	DEFICIENCI)	DATE	
	· · · · · · · · · · · · · · · · · · ·	A #6 indicated as long as					
		could enter a resident's					
		ot have to wait for them					
	to respond.						
	2 During on oh	correction on 12/12/2012					
	_	servation on 12/13/2013 rtified Nursing Assistant					
		bserved to enter Resident					
		JA #2 failed to knock					
		Resident #16's room.					
	prior to entering	Resident #10 \$ 100m.					
	During an observ	vation on 12/16/2013 at					
	~	ident #16 was observed					
	· · · · · · · · · · · · · · · · · · ·	r in front of the nurse's					
		t #16 asked CNA #3 to					
		erself to her room. CNA					
	_	owledge Resident #16's					
		ked away. Resident #16					
		ask housekeeper staff #4					
		o her back to her room.					
	1	stated, "No, I don't think					
	I can do that."	stated, 100, I don't tillik					
	1 van av mat.						
	Resident #16's re	ecord was reviewed on					
		40 A.M. Resident #16					
		hich included, but were					
		ngestive heart failure,					
	anemia, and diab	-					
	,						
	A care plan date	d 11/4/2013, indicated					
		ed easily and staff were					
		ort as needed with					
		and from activities.					
	_						
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PRINTED: 06/16/2014 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	LDING	NSTRUCTION 00	(X3) DATE COMPI 12/19	ETED
	PROVIDER OR SUPPLIER		STREET A	ODDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Assessment tool indicated Reside chair for transpo extensive physic	Minimum Data Set dated 10/31/13, nt #16 utilized a wheel rtation and required al assistance of one staff in to and from activities				
	10:24 A.M., CN. #16 could propel chair but sometin help if she was to	iew on 12/18/2013 at A #5 indicated Resident herself in her wheel mes she would ask for too tired. She indicated her if she needed the				
	dated 5/23/2013, expressed concer	ent Council minutes indicated residents rns regarding, "CNA e I don't care attitude care"				
	dated 7/25/2013, expressed concerthem their names "CNAs being ranswered timely	ent Council minutes indicated residents rns with staff not telling s prior to providing care, rude call lights not staff are disrespectful able for assistance"				
	dated 8/29/2013, service issues co	ent Council minutes indicated, "CNA ntinue to be concerns were issues of				

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Event ID:

7BUW11 Facility ID: 001156

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PRINTED: 06/16/2014 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION OF CORRECTION 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/19/2013		
	PROVIDER OR SUPPLIER RUN HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION		
	Review of Resident Council minutes dated 9/19/13, indicated, "continued concern about CNA service consistencyCNA service-politeness and answering call lights viewed as inconsistent" Review of Resident Council minutes dated 10/17/2013, indicated, "timeliness of call lights inconsistent. At times prolonged" Review of Resident Council minutes dated 11/20/17, indicated, "answering call lights still of concern. Also, service professionalism is inconsistent. Some workers are kind-others are not" During an interview on 12/19/2013 at 10:30 A.M., the administrator indicated the facility had provided on going inservices in response to the residents complaints of staff attitudes and prolonged call light answer times. She indicated it was her expectation staff should always treat residents with respect and dignity and respond to their calls for assistance promptly and respectfully. 3.1-3(t)					

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7BUW11 Facility ID: 001156

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
NAME OF PROVIDER OR SUPPLIER ROBIN RUN HEALTH CENTER SITER TADDRESS, CITY, STATE, ZIP CODE (6370 ROBIN RUN W INDIANAPOLIS, IN 48288 SUMMARY STATEMENT OF DESICIENCIES (BACH DESPICIENCY MUST BE PRECEDED BY FULL TAG BEGULATORY OR LISC BINITY WAS THO COMPLETED. TAG SUMMARY STATEMENT OF DESICIENCIES (BACH DESPICIENCY MUST BE PRECEDED BY FULL TAG BEGULATORY OR LISC BINITY WAS THOUSED. The resident has the right to choose activities, schedules, and health care consistent with his or her infer resids, assessments, and plans of care; interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #39). Findings include: 1. During an observation on 12/13/2013 at 10:51 AM., CNA [Certified Nursing Assistant] #6 was observed to enter Resident #900 soon, hand Resident #90 a cup of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9-40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15.	AND PLAN	OF CORRECTION		A. BUILDING 00				
ROBIN RUN HEALTH CENTER CX9 ID			155505			12/19/2013		
ROBIN RUN HEALTH CENTER (X4) ID PREETX CHARTOP DEPRCENCY MCST BE PRECEDED BY BULL TAG REGALATORY OR ISC DENTIFYING REPORTATION) FO00242 SS=E FO00242 SS=E FO00242 SS=E REGALATORY OR ISC DENTIFYING REPORTATION) FO01242 SS=E The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessment, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #39). Findings include: 1. During an observation on 12/13/2013 at 10.51 AM., CNA (Certified Nursing Assistant) #6 was observed to enter Resident #90's room, hand Resident #90 a cup of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9.40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15.	NAME OF P	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•		
SUMMARY STATEMENT OF DEFICIENCIES TAG CRACH DEFICIENCY MIST BE PRECEDED BY BILL. TAG CRACH DEFICIENCY MIST BE PRECEDED BY BILL. TAG CRACH DEFICIENCY MIST BE PRECEDED BY BILL.								
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION SSEE ABSE A	ROBIN R	UN HEALTH CENT	ER	INDIAN	NAPOLIS, IN 46268			
TAG RECILATORY OR ISC IDENTIFYING INFORMATION) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #39). Findings include: Findings include: 1. During an observation on 12/13/2013 at 10:51 AM., CNA [Certified Nursing Assistant] #6 was observed to enter Resident #90's room, hand Resident #90 ac up of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9:40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [Porief interview ment als status assessment tool] score of 15 out of 15.		SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
FO00242 SS=E AB3.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with is or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #18, Resident #90, and Resident #39). Findings include: 1. During an observation on 12/13/2013 at 10:51 AM., CNA [Certified Nursing Assistant] #6 was observed to enter Resident #90's room, hand Resident #90 ac cup of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9-40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15.		`			CROSS-REFERENCED TO THE APPROPRIA	IIE		
SS=E SELF-DÉTERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility, and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review, and interview, the facility failed to ensure residents were given an opportunity to make choices regarding their care. This deficient practice affected 3 of 8 residents reviewed for choices (Resident #18, Resident #90, and Resident #39). Findings include: Findings include: 1. During an observation on 12/13/2013 at 10:51 AM., CNA [Certified Nursing Assistant] #6 was observed to enter Resident #90's room, hand Resident #90 a cup of water, and ask her if she needed anything. Resident #90's record was reviewed on 12/18/2013 at 9:40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15.	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
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Resident #90's record was reviewed on 12/18/2013 at 9:40 A.M. A quarterly MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15. discharged from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:Cognitively intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations			nd ask her if she needed		1 '			
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potential to be affected by the same deficient practice will be identified and what corrective action (s) will be taken:Cognitively intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations						ow		
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MDS [Minimum Data Assessment Tool] dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15. identified and what corrective action (s) will be taken:Cognitively intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations		12/18/2013 at 9:4	40 A.M. A quarterly		1 '			
dated 10/31/2013, indicated Resident #90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15. action (s) will be taken:Cognitively intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations		MDS [Minimum	Data Assessment Tool]		· · · · · · · · · · · · · · · · · · ·			
#90's cognitive status was intact with a BIMS [brief interview mental status assessment tool] score of 15 out of 15. intact residents have been interviewed regarding bathing preferences and reasonable individualized accommodations		dated 10/31/2013	3, indicated Resident			ively		
BIMS [brief interview mental status assessment tool] score of 15 out of 15. interviewed regarding bathing preferences and reasonable individualized accommodations								
assessment tool] score of 15 out of 15.		_						
		_			1 -	ne		
I I NAVE DEED MADE HOW MEASURES I			STOLD OF 15 OWN OF 15.		have been made. How measu			

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE			ETED	
		155505				12/19/	/2013
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIEF	₹					
DODIN D		TED			OBIN RUN W		
RUBIN R	ROBIN RUN HEALTH CENTER			INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	During an interv	riew on 12/13/2013 at			will be put into place or what		
	10:51 A.M., Res	sident #90 indicated she			systematic changes will be ma to ensure that the deficient	ade	
	had complained	about CNA #6 being			practice does not recur:Reside	onte	
	_	ectful to her and had			will be interviewed per the	51113	
	-	ot be assigned to care for			comprehensive care plan		
	_	e indicated her son had			schedule about aspects of life	in	
					the facility that are significant		
	called and requested the same but the				the individual and reasonable		
	facility had not h	nonored her request.			individualized accommodation		
					will be made. How the correct	ive	
	During an interv	riew on 12/13/2013 at			action(s) will be monitored to ensure deficient practice will r	ot	
	10:51 A.M., CN	A [Certified Nursing			recur, i.e., what quality assura		
	Assistant] #6 inc	licated she was assigned			programs will be put into place		
	to Resident #90.				self-determination Quality		
					Assurance Performance		
	During on interes	riew on 12/17/2013 at			Improvement audit tool will be		
					utilized weekly times 4 weeks		
		the Administrator and			then bi-weekly times 4 weeks,		
		the ADON indicated a			and then monthly until the alle	-	
		ent #90 requested CNA			deficient practice does not rec The Quality Assurance	ur.	
	#6 not be assign	ed to her. The ADON			Performance Improvement au	dits	
	indicated she rer	noved CNA #6 from			will be reviewed in the monthly		
	Resident #90's a	ssignment for the rest of			Quality Assurance Performan	•	
		ved her to care for her			Improvement meetings by the		
	after that day.				Quality Assurance Performan	ce	
	arter that day.				Improvementcommittee.		
	2 Dagidant #20	's record was reviewed					
		t 9:50 A.M. An annual					
	MDS dated 10/1						
		ognitive status was intact					
	with a BIMS sco	ore of 13 out of 15.					
	During an interv	riew on 12/13/2013 at					
		lent #39 indicated he did					
	-	e regarding his shower					
		dicated his shower					
	i schedule. He in	uicateu iiis siiowei	1		i e e e e e e e e e e e e e e e e e e e		Ī

PRINTED: 06/16/2014 FORM APPROVED OMB NO. 0938-0391

IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPL 12/19/	ETED
PROVIDER OR SUPPLIER		<u> </u>	STREET A	DDRESS, CITY, STATE, ZIP CODE DBIN RUN W APOLIS, IN 46268		
SUMMARY S' (EACH DEFICIEN REGULATORY OR Schedule was destaff. 3. Resident #18' on 12/18/2013 at scheduled MDS Resident #18's co with a BIMS sco. During an interv 11:54 A.M., Res was not allowed schedule. She st once a week. I h Thursday. I wou whenever I want tell me my show Thursday. I wou showers a week feel." During an interv 2:30 P.M., the A unless a resident did not have a sy who resided in the to make choices			6370 RC	OBIN RUN W	ATE	(X5) COMPLETION DATE
3.1-3(u)(1) 3.1-3(u)(3)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7BUW11 Facility ID: 001156

If continuation sheet

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/19/2013		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE		
F000247 SS=D	before the resident the facility is changed and record the facility failed given notice prior for 1 of 8 resident prior to change in (Resident #90). Findings include Resident #90's resi	TE CHANGE right to receive notice t's room or roommate in ged. review and interview, It to ensure residents were or to a roommate change ints reviewed for notices in room or roommate	F000247	Right to Notice Before Room/Roommate Changelt i practice of the provider to no residents before the room or roommate in the facility is changed.What corrective act will be accomplished for thos residents found to have beer affected by the deficient practice:The most recent roommate change for Reside #90 was on 9/3/13. How othe residents having the potentia be affected by the same defic practice will be identified and what corrective action (s) will taken:The Social Service Din has been re-educated related the standard of notification at documentation of room or roommate changes. What measures will be put into play what systematic changes will made to ensure that the defice	tify ions e in ent er I to cient be ector d to nd ce or I be		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7BUW11 Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	a. Building 00		COMPLETED	
		155505	B. WING		12/19/2013	
		<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIE	R		ROBIN RUN W		
ROBIN R	UN HEALTH CEN	TER	INDIANAPOLIS, IN 46268			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	During an interv	view on 12/13/2013 at		practice does not recur:The		
	10:46 A.M., Res	sident #90 indicated she		Social Service Director has be	een	
	· ·	roommate changes and		re-educated related to the		
		d notice to the roomate		standard of notification and documentation of room or		
	•	ted, "They just bring		roommate changes. How the		
	_	ited, They just offing		corrective actions will be		
	them in."			monitored to ensure the defici	ent	
				practice will not recur, i.e., wh	at	
	_	view on 12/18/13 at 9:15		quality assurance program wil	l be	
	A.M., the Admi	nistrator indicated		put into place:A notification		
	documentation	was not available which		Quality Assurance Performan		
	indicated Reside	ent #90 received notice		Improvement audit tool will be utilized weekly times 4 weeks		
	prior to her roor	nmate moving into her		then bi-weekly times 4 weeks		
	-	cated it was the facility's		and then monthly until the alle		
		rm residents of room		deficient practice does not		
	_			recur.The Quality Assurance		
	_	and to document the		Performance Improvement		
	notification in the	ne resident's record.		interview tool will be reviewed		
				the monthly Quality Assurance	e	
	3.1-3(v)(2)			Performance Improvement meeting by the Quality Assura	unaa	
				Performance Improvement	ince	
				committee.		
	400.00(1) 400.00	24.742				
F000279	483.20(d), 483.20	* * * *				
SS=G	PLANS	PREHENSIVE CARE				
		e the results of the				
	-	evelop, review and revise				
		nprehensive plan of care.				
		•				
		develop a comprehensive				
		resident that includes				
	-	ctives and timetables to				
		medical, nursing, and				
		nosocial needs that are omprehensive assessment.				
	i identined in the C	omprenensive assessificiti.				
			1	1	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	155505	A. BUILDING	00	12/19/2013
		100000	B. WING	CADDREGG CITY GTATE TIN CODE	12/10/2010
NAME OF 1	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE ROBIN RUN W	
ROBIN F	RUN HEALTH CEN	TER		NAPOLIS, IN 46268	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL R I SC IDENTIFYING INFORMATION)	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG	The care plan muthat are to be furn that are to be furn the resident's hig mental, and psyc required under §4 that would otherw §483.25 but are resident's exercis including the righ §483.10(b)(4). Based on observinterview, the far plan of care for interventions to resulted in harm evidenced by a increasing to a service of care plans for #11). Findings: During an observint presidents review of care plans for #11). Findings: During an observed to stage III open are Resident #11's	a LSC IDENTIFYING INFORMATION) Ist describe the services hished to attain or maintain hest practicable physical, hosocial well-being as 483.25; and any services vise be required under not provided due to the se of rights under §483.10, at to refuse treatment under vation, record review, and acility failed to develop a pressure areas with promote healing which in to a resident as stage I pressure area. Tractice affected 1 of 1 are defor the development of the pressure areas (Resident for the development of the pressure areas (Resident for the development of the pressure area (Resident for the development of the pressure area (Resident for the development of the developm	F000279	Develop Comprehensive Care PlansIt is the practice of the provider to use the results of t assessment to develop, review and revise the resident's comprehensive plan of care.T provider is respectively reques an Informal Dispute Resolutio review to focus on the scope a severity for this citation, as the documentation does not supp the allegation that Resident # experienced actual harm. The pressure area was identified of 11/20/13. The physician was immediately notified and a new treatment order was obtained implemented. There is documentation on the Medica Administration Record to supp that the treatment was consistently applied per the physician's order. The documentation in the Nursing Note, Medication Administration Record, and Weekly Skin Inte Review (all entered on 11/20/ reflect that there was an "oper area". This documentation de not support the allegation that pressure area progressed from Stage I to a Stage III. What	DATE O1/18/2014 he w, his sting n and e ort 11 e on w and tion port on grity 13) n bes the

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Event ID:

7BUW11 Facility ID: 001156

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIW DDIG	00	COMPLETED
		155505	A. BUILDING	·	12/19/2013
			B. WING	ET ADDRESS SITV STATE ZID CODE	
NAME OF F	PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP CODE	
DODINID		TED		ROBIN RUN W	
KORIN K	RUN HEALTH CEN	IER	INDI	ANAPOLIS, IN 46268	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP	E COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	The record lack	ed documentation of a		corrective actions will be	
	care plan which addressed Resident #11's			accomplished for those resi	
	history of pressu	ire areas.		found to have been affected	
				the deficient practice:Reside	ent#
	An untimed nur	aala mata datad		11's plan of care has been reviewed/revised. How othe	r
				residents having the potenti	I
	· ·	icated, "CNA [Certified		be affected by the same def	
	Nursing Assista	nt] reported small open		practice will be identified an	
	area with slight	redness to coccyx/sacral.		what corrective action (s) wi	
	Physician office	notified n/o [new order]		taken:The plan of care for	
	for EPC [cream] q [every] shift."		residents with pressure sore	
		, 4[-,,]		have been reviewed/revised	
	The maceud leals	ed documentation of the		What measures will be put i	
				place or what systemic char	-
		und, or the stage of the		will be made to ensure that	ine
	wound.			deficient practice does not recur:The licensed nursing s	stoff
				have been re-educated on t	I
	An untimed phy	sician's order dated		provider's protocols for	
		cated the physician		communication of, and Care	e Plan
	· ·	al mattress to be placed on		development for, any chang	
	_	_		skin condition.The Unit Man	ager
		ped, Resident #11 was to		or her designee will audit the	
		d except for meals, and a		orders and clinical status ch	
	special cushion	[roho] was to be placed		log daily to assist with comp	liance
	in his recliner.			with proper Care Plan	:
				development for any change	
	The record indic	cated a care plan was not		skin condition. How the correlation (s) will be monitored	I
		veloped when the open		ensure the deficient practice	I
	1	veloped when the open		not recur, i.e., what quality	, Will
	area was noted.			assurance program will be p	out
	_			into place:A skin condition C	I
		ation flow sheet dated		Assurance Performance	
	12/4/2013, indic	cated Resident #11's		Improvement audit tool will I	I
	pressure area wa	as staged at a stage 3,		utilized weekly times 4 week	
	_	entimeters [cm] in length,		then bi-weekly times 4 week	
		, and 0.3 cm in depth, had		and then monthly until the a	lieged
		of serous exudates, the		deficient practice does not recur. The Quality Assurance	_
		,		Performance Improvement	
	wound bed had	100 percent granulation,		i enormance improvement	addit

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 12/19/	ETED
	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
TAG	the periwound w surrounding tissue. A wound care evidated 12/7/2013, wound improved measurements of width, and 0.2 cm. During an intervitie 11:16 A.M., the the nurse who di wound failed to twenty-four hour Administrator in in notifying the videlay in develop interventions in a wound healing. During an intervity 9:47 A.M., the faindicated he was #11's pressure with He indicated the open and indicted aggressively treat been notified of discovered on 11 soon as he found immediately contobtained orders to the date of the surrounding time of the surroundin	as red, and the ne was red/pink. raluation flow sheet indicated Resident #11's slightly with fl.8 cm length, 1.2 cm m depth. iew on 12/18/2013 at Administrator indicated scovered the pressure document it on the report. The dicated there was a delay wound care nurse and a ing and implementing a care plan to facilitate iew on 12/19/2013 at accility's wound nurse not notified of Resident ound until 12/4/2013. area had previously been		TAG	tool will be reviewed in the monthly Quality Assurance Performance Improvement meeting by the Quality Assura Performance Improvement		DATE
ı	the roho cushion	in his recliner. The					

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	of Correction identification number: 155505	A. BUILDING B. WING	00	COMPLETED 12/19/2013
	PROVIDER OR SUPPLIER	6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	facility's wound care nurse stated, "He did not have the special mattress or the roho cushion in his recliner until I saw him."			
	During a telephone interview on 12/19/2013 at 10:24 A.M., Licensed Practical Nurse [LPN] #1 indicated she was the nurse who first noted the open area. She stated, "He had a little spot so I called the doctor I am not a wound nurse and I don't know a lot about wounds I should have put it on the 24 hour report sheet but I didn't"			
	A document dated 2010, and titled "Pressure Ulcers/Skin Breakdown-Clinical Protocol" identified as a current facility policy by the Administrator on 12/18/2013 at 1:27 P.M., indicated, "Assessment and Recognitionthe nurse shall assess and document/report the followingfull assessment of pressure sore including location, stage, length, width, and depth, presence of exudates or necrotic tissue The physician will help the staff review and modify the care plan as appropriate, especially when new wounds develop despite existing interventions"			

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AND PLAN	ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155505 A. BUILDING B. WING			COMPLETED 12/19/2013			
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 6370 ROBIN RUN W INDIANAPOLIS, IN 46268				
(X4) ID PREFIX TAG	(EACH DEFICIEN	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
F000314 SS=G	PRESSURE SORI Based on the com a resident, the faci resident who enter pressure sores do sores unless the ir condition demonst unavoidable; and a sores receives ned services to promot infection and prevedeveloping. Based on observatinterview, the fact residents with prompt necessary to promote healing harm to a resident I pressure area in pressure area. The affected 1 of 1 respressure areas granger (Resident #11). Findings include During an observation of the pressure area of the pressure area.	prehensive assessment of lity must ensure that a state facility without es not develop pressure advidual's clinical rates that they were a resident having pressure researcy treatment and e healing, prevent ent new sores from ation, record review, and cility failed to ensure ressure sores received a treatment and services and which resulted in that as evidenced by a stage recreasing to a stage III is deficient practice residents reviewed with reater than stage 2	F0003	314	Treatment/Services to Prevent/Heal Pressure SoresIt the practice of the provider to ensure that each resident receives treatment/services for pressure sores to promote healing, prevent infection, and prevent new sores from developing. This provider is respectfully requesting an Informal Dispute Resolution review as the documentation does not support the allegation that Resident #11 experienced actual harm. The documentati does support that Resident #1: received prompt necessary treatment and services to promote healing. The pressure area was identified on 11/20/13. The physician was immediately	on 1 e 3.	01/18/2014

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJI	LDING	00	COMPLETED	
		155505				12/19/	2013
			B. WIN		ADDRESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP CODE		
DODINE	NINILIEAL TIL OFNI				OBIN RUN W		
KOBIN F	RUN HEALTH CENT	IER		INDIAN	APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	stage III open ar	ea to his left buttock.			notified on 11/20/13 and a new	v	
					treatment order was obtained	and	
	Resident #11's re	ecord was reviewed on			implemented. There is		
					documentation on the Medicat		
		52 A.M. Resident #11			Administration Record to supp	ort	
		hich included but were			that the treatment was		
	· ·	ementia, multiple			consistently applied per the physician's order. The		
	sclerosis, conges	stive heart failure, and a			documentation in the Nursing		
	history of pressu	ire areas.			Note, Medication Administration	n l	
					Record, and the Weekly Skin		
	The record lacks	ed documentation of a			Integrity Review (all entered or	n	
					11/20/13) reflect that there was		
	-	addressed Resident #11's			an "open area"; this would not		
	history of pressu	ire areas.			considered a Stage I pressure		
					area according to standard of		
	An untimed nurs	se's note dated			practice. This documentation		
	11/20/2013, indi	cated, "CNA [Certified			does not support the allegation that the pressure area	1	
	· ·	nt] reported small open			progressed from a Stage I to a	,	
	_	redness to coccyx/sacral.			Stage III. In addition, the	'	
	_	notified n/o [new order]			documentation supports that the	ne	
					provider had preventative		
	for EPC [cream]	q [every] shift."			measures in place as appropri	ate	
					for this at-risk resident. The		
	The record lacke	ed documentation of the			Medication Administration Rec		
	wound, peri-wou	and, or the stage of the			indicates that pressure reducir		
	wound.	_			surfaces were in place in the b	ed	
					and the wheelchair, he was		
	An untimed phy	sician's order dated			also receiving nutritional supplements as recommended	d by	
					the Registered Dietician. The	J Dy	
	•	ated the physician			documentation also supports t	hat	
	_	l mattress to be placed on			the nursing department was		
	Resident #11's b	ed, Resident #11 was to			monitoring the resident's skin	on	
	remain in his be	d except for meals, and a			a routine basis and new treatm	nent	
	special cushion	[roho] was to be placed			was implemented at the time t	hat	
	in his recliner.				the open area was		
					identified. What corrective acti		
	The man 1 in 1'				will be accomplished for those		
		ated a care plan was not			residents found to have been		
	immediately dev	reloped when the open			affected by the deficient		

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155505	B. WING			12/19/2	2013
		1			ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF F	PROVIDER OR SUPPLIE	R			OBIN RUN W		
	RUN HEALTH CEN	TER			IAPOLIS, IN 46268		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	T	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		and did not indicate a care			practice:Resident #11 pressu	re	
	1 1	ing pressure ulcers prior			sore was assessed by the physician on 12/6/13 with new	,,	
	to 12/4/13.				orders implemented. The wor		
					is being monitored per the	J. 10	
	A wound evalua	ation flow sheet dated			provider's protocols. How oth	er	
		cated Resident #11's			residents having the potential		
	1				be effected by the same defic	cient	
		as staged at a stage 3,			practice will be identified and		
		entimeters [cm] in length,			what corrective actions will be		
	l	, and 0.3 cm in depth, had			taken:Residents with pressur		
	a scant amount	of serous exudates, the			sores are being followed pert	ne	
	wound bed had	100 percent granulation,			provider's protocols. What measures will be put into place	e or	
	the periwound v	-			what systemic changes will b		
	-	ue was red/pink.			made to ensure that the defic		
		as rea print.			practice does not recur:The		
	A mound	valuation flow sheet			licensed nursing staff have be	een	
		valuation flow sheet			re-educated on the provider's		
		, indicated Resident #11's			protocols for communication		
	1	roved slightly with			changes in skin condition.The		
	measurements of	of 1.8 cm length, 1.2 cm			DON or designee will audit th		
	width, and 0.2 c	m depth.			wound report weekly to assis with compliance of	۱	
					treatment/services to promote	<u> </u>	
	During an interv	view on 12/18/2013 at			wound healing.How the corre		
	I -	Administrator indicated			action (s) will be monitored to		
	· · · · · · · · · · · · · · · · · · ·	iscovered the pressure			ensure deficient practice will		
		*			recur, i.e., what quality assura		
		document it on the			program will be put into place	::A	
	twenty-four hou	•			new skin condition Quality		
	Administrator ii	ndicated there was a delay			Assurance Performance	,	
	in notifying the	wound care nurse and a			Improvement audit tool will be utilized weekly times 4 weeks		
	delay in develor	oing and implementing			then bi-weekly times 4 weeks		
		a care plan to facilitate			then monthly until the alleged		
	wound healing.				deficient practice does not		
	wound nearing.				recur.The Quality Assurance		
	Daning and in	12/10/2012			Performance Improvement au		
	~	view on 12/19/2013 at			will be reviewed in the month		
	· ·	facility's wound nurse			Quality Assurance Performar		
	indicated he was	s not notified of Resident			Improvement meetings by the	•	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155505	(X2) MULT A. BUILDI B. WING		00	(X3) DATE (COMPL 12/19/	ETED
	PROVIDER OR SUPPLIER		6	370 RC	DDRESS, CITY, STATE, ZIP CODE DBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
IAG	#11's pressure w He indicated the open and indicte aggressively trea been notified of discovered on 11 soon as he found immediately con obtained orders to a low air loss matthe roho cushion facility's wound did not have the roho cushion in I him." During a telephon 12/19/2013 at 10 Practical Nurse [was the nurse wharea. She stated, called the doctor nurse and I don't wounds I show hour report sheet. A document date "Pressure Ulcers Breakdown-Clin as a current facil Administrator or P.M., indicated,	ound until 12/4/2013. area had previously been d he would have ted the area if he had the area when it was /20/13. He indicated as l out about the wound he tacted the doctor and to change his mattress to attress and implemented in his recliner. The care nurse stated, "He special mattress or the his recliner until I saw me interview on 224 A.M., Licensed LPN] #1 indicated she ho first noted the open "He had a little spot so I I am not a wound know a lot about uld have put it on the 24 the but I didn't" ed 2010, and titled /Skin ical Protocol" identified		AG	Quality Assurance Performance Improvement committee.	ee	DATE
	document/report	the followingfull					

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	OF CORRECTION	IDENTIFICATION NUMBER: 155505	A. BUILDING B. WING		00	COMPLETED 12/19/2013	
	ROVIDER OR SUPPLIER		J. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	location, stage, le presence of exud The physician wi and modify the c	essure sore including ength, width, and depth, ates or necrotic tissue ill help the staff review are plan as appropriate, new wounds develop nterventions"					
	3.1-40(a)(2)						
F000329 SS=D	from unnecessary drug is any drug w dose (including du excessive duration monitoring; or with for its use; or in the consequences whi						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155505	B. WIN	G		12/19/	/2013
NAME OF F	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					OBIN RUN W		
ROBIN R	UN HEALTH CENT	TER		INDIAN	IAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	ICY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG	combinations of th	<u> </u>	+	TAG			DATE
	· ·	rehensive assessment of a					
		ty must ensure that					
	residents who have not used antipsychotic drugs are not given these drugs unless						
		therapy is necessary to					
		ndition as diagnosed and					
		e clinical record; and					
		e antipsychotic drugs					
	_	ose reductions, and ntions, unless clinically					
		an effort to discontinue					
	these drugs.						
	Based on record	review and interview,	F00	0329	Drug Regimen is Free From		01/18/2014
	the facility failed to ensure behavior				Unnecessary DrugsIt is the practice of the provider to ensi	ure	
	interventions we	ere attempted prior to			that each resident's drug regimen		
	administering PI	RN [as needed]			is free from unnecessary		
		nedications. This			drugs.What corrective actions will be accomplished for those		
	•	e affected 1 of 5 residents			residents found to have been		
		necessary medications			affected by the deficient		
	(Resident #116).				practice:The licensed nursing		
	Findings include	•			staff have been re-educated o the provider's protocols for	n	
	Tillulings illerude	··			administration and documenta		
	Resident #116's	record was reviewed on			of use of as-needed psychotro medication. How other resider		
		0 P.M. Resident #116			having the potential to be affect		
		hich included, but were			by the same deficient practice	will	
	_	Izheimer's dementia,			be identified and what correcti	ve	
	depression, and				action(s) will be taken:The licensed nursing staff have be	Δn	
	-F	· ·			re-educated on the provider's	011	
	An untimed phys	sician's order dated			protocols for administration an	d	
		l, "Haldol [anti-psychotic			documentation on the use of		
		mg [milligrams] tablet by			as-needed psychotropic		
	mouth every 6 hours as needed times 2				medication. What measures will be put into place or what systemic		
	weeks and then				changes will be made to ensur		
	agitation."				that the deficient practice does	5	

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPLETED	
		155505	B. WIN			12/19/2013	
			B. WII.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	8			OBIN RUN W		
ROBIN R	UN HEALTH CENT	ΓER			APOLIS, IN 46268		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
IAU	The MAR [medirecord] dated Au Resident #116 w [as needed] Halo 8/10/2013 through A document title Note", dated 8/1 indicated no beh On 8/11/13 throunursing notes haredirection or no interventions beth Haldol. A care plan date Resident #116 hirestlessness as even ain in his who agitated and com Non pharmacological attempted prior to the PRN antipsy. During an intervention, with the August 116 prior to the PRN antipsy.	ication administration ugust 2013, indicated vas administered the PRN dol thirteen times from		IAU	not recur:The licensed nursing staff have been re-educated of the provider's protocols for administration and documentation the use of as-needed psychotropic medication. How corrective action(s) will be monitored to ensure that the deficient practice will not recur i.e., what quality assurance program will be put into place: as-needed psychotropic medication Quality Assurance Performance Improvement to will be utilized weekly times 4 weeks, then bi-weekly times 4 weeks, and then monthly until alleged deficient practice does not recur. The Quality Assuran Performance Improvement au will be reviewed in the monthly Quality Assurance Performance Improvement au monthly Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvement committee.	tion the , An of the ce dits , ce	
		<i>⊖</i> ∟ - 'J	1				

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155505	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 12/19/2013
	PROVIDER OR SUPPLIER	6370 R	ADDRESS, CITY, STATE, ZIP CODE OBIN RUN W APOLIS, IN 46268	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION
	present, the Administrator indicated Resident #116 was admitted with orders for the PRN Haldol [anti-psychotic] medication. She further indicated the Haldol was used because Resident #116 had a behavior of "attempting to get up out of his chair." She indicated if staff tried to prevent him from standing he became "combative." The administrator indicated documentation was not available which indicated non-pharmacological interventions were consistently attempted prior to each administration of the PRN Haldol. A policy dated 2005, and titled "antipsychotic Drugs" identified as current by the Administrator on 12/19/2013 at 10:34 A.M., indicated, "AS NEEDED or P.R.N. Antipsychotic Drugs should only be used when the resident has a specific condition for which antipsychotic drugs are indicatedThe as needed or P.R.N. dose is being used to manage unexpected harmful behaviors that cannot be managed without antipsychotic drugs" 3.1-48(a)(4) 3.1-48(b)(2)			
F000364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH	LDING	00	COMPL	ETED
		155505	B. WIN			12/19/	/2013
		l .	B. WIN		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIER	R			OBIN RUN W		
ROBIN R	RUN HEALTH CENT	TER			IAPOLIS, IN 46268		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		pared by methods that					
	conserve nutritive						
	appearance; and food that is palatable, attractive, and at the proper temperature.						
		ration, interview, and	F00	0364	Nutritive Value/Appearance,		01/18/2014
		ne facility failed to ensure	100	0304	Palatable/Prefer TemperaturesIt is the practice of the provider to		01/10/2014
	·	•					
		at proper temperatures.			serve meals to the residents the		
		ractice affected 2 of 8			are prepared by methods that		
	residents review	ed for food quality			conserve nutritive values, flavo	or,	
	(Resident #39, a	nd Resident #90).			and appearance, and that is	_	
					palatable, attractive, and at the proper temperature. What	9	
	Findings include				corrective actions will be		
					accomplished for those reside	nts	
	During an observ	vation on 12/18/2013 at			found to have been affected by		
					the deficient practice:The Diet	ary	
	-	n the Administrator and			and Nursing Departments hav	е	
		present, dietary staff #8			modified the processes of		
	_	ature of food prepared for			preparation and delivery of roc	om	
	a resident. The t	temperatures were:			tray service to assist with compliance of maintaining		
	Chicken pot pie-	·100 degrees, wax			temperatures within acceptable	e	
	beans-80 degree	s, potatoes-80 degrees.			standards (which are 140	•	
		-			degrees or abovefor hot foods		
	During an interv	riew on 12/13/2013 at			and 40 degrees or below for co	old	
	_	sident #90 indicated the			foods) when served to the		
	l '	s not served at proper			individual residents. How othe		
	_	1 1			residents having the potential		
	_	he stated, "it is either			be affected by the same defici practice will be identified and	ent	
	warm or cold bu	t seldom hot"			what corrective action (s) will be	ne	
					taken:The Dietary and Nursing		
	During an interv	riew on 12/13/2013 at			Departments have modified th		
	2:13 P.M., Resi	dent #39 indicated the			processes of preparation and		
	food was not ser	rved at proper			delivery of room tray service to)	
		le stated, "Sometimes			assist with the compliance of		
	_	ometimes food is cold			maintaining temperatures with		
					acceptable standards (which a	are	
	_	get somebody to warm it			140 degrees or above for hot foods and 40 degrees or below	٨/	
		gotten cold and by then I			for cold foods) when served to		
	have lost my apr	netite "			I is sold loods, which solved to		I

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(Y2) M	X2) MULTIPLE CONSTRUCTION			SLIDVEA	
					(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING		00	COMPLETED		
155505		B. WING			12/19/2013			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
White of Trovider or soft elek			6370 ROBIN RUN W					
ROBIN RUN HEALTH CENTER			INDIANAPOLIS, IN 46268					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE	
	During an interview on 12/18/2013 at 12:40 P.M., Dietary staff #8 indicated the chicken pot pie temperature should have been 145 to 160 degrees, the wax beans and the potatoes should have been 140 degrees. An undated policy titled "Food Temperatures" identified as current by Dietary Staff #8 on 12/18/2013 at 1:00 P.M., indicated, "Foods should be served at proper temperature to insure food safety and palatability Appropriate serving temperatures are: casseroles equal to or greater than 140 degrees but preferable 140 to 165 degrees F [Fahrenheit] potatoes equal to or greater than 140 degrees but preferably 140-165 FVegetables equal to or greater than 140 degrees but preferably 140-165 F"				measures will be put into place what systematic changes will I made to ensure that the deficie practice does not recur: The Dietary and Nursing Departmentary and Nursing Departmentary emodified the processes of preparation and delivery of roctural transpersion and delivery of roctural transpersion and transpers	be ent ents of om e very		
					appropriate ranges. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., who quality assurance programs who put into place. A room tray Quality Assurance Performance Improvement audit tool will be utilized weekly times 4 weeks, and then monthly until the alle deficient practice does not recommend the province of the Quality Assurance Performance Improvement auwill be reviewed in the monthly Quality Assurance Performance Improvement meetings by the Quality Assurance Performance Improvement	at ill ce ged ur. dits y		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

7BUW11 Facility ID: 001156